CENTER FOR HEALTH INFORMATION AND ANALYSIS
2015 ANNUAL PREMIUMS DATA REQUEST
SUMMARY

The 2015 Center for Health Information and Analysis' (CHIA) Annual Premiums Data Request (Request) asks for payer and third-party administrator information about commercial health insurance products issued and administrative services provided in the Commonwealth of Massachusetts. This Request allows for the annual analysis of Massachusetts contract-membership, premium values, benefit levels, cost sharing, medical claims, and payer retention. The results from last year's Request can be found here.

For 2015, CHIA continues to request aggregate data on commercial market membership, premiums, and claims by market sector (employer group size), managed care type (HMO, PPO), and product type (high-deductible health plans, tiered networks). These data allow CHIA to better inform policymakers and the general public of the evolving health care landscape in Massachusetts, while allowing valuable insight into how recent state and federal reforms (e.g. Chapter 224 of the Acts of 2012, the Patient Protection and Affordable Care Act) have impacted health care access and affordability.

As with previous Requests, data are requested for the previous three calendar years - 2012, 2013, and 2014 - for all primary, medical commercial health insurance members who are covered under a policy issued in Massachusetts, including those members who reside outside of Massachusetts; this includes members of both fully- and self-insured plans and members of all group sizes. Excluded from this Request are the following types of business: Medicare Advantage, Commonwealth Care, Medicaid Managed Care, Medicare Supplement, Federal Employee Health Benefit Plan (FEHBP), Medical Security Program, and other non-primary, non-medical business.

The attached Data Template workbook should be used for data submission. **Separate Excel workbooks should be submitted for each legal entity writing Massachusetts business, including affiliates that write only self-insured business**.

All quality-checked data submissions should be sent to Dianna Welch of Oliver Wyman Actuarial Consulting, Inc., at dianna.welch@oliverwyman.com by Wednesday, May 6th, 2015 at 5pm. Any technical questions relating to specifications or the workbook should be directed to Dianna Welch at dianna.welch@oliverwyman.com or at (414) 277-4657.

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REQUEST SPECIFICATIONS

Please provide the following data in the attached Excel workbook **for each calendar year 2012, 2013, and 2014 for all members who were covered under a commercial, primary, medical policy issued in or administrative product delivered in Massachusetts, regardless of member state residency.** Each Specification element corresponds to a tab or set of tabs within the attached Data Template workbook. (*Note: While most elements have not changed, many have been rearranged from the 2014 Request.)*

MEMBERSHIP

A. Please provide **member months** information by Insurance Funding Type, Market Sector, Managed Care Type, Product Type, and Geographic Area.

B. Please provide **member months** information by Insurance Funding Type, Market Sector, Managed Care Type, and Product Type, by 5-Year Age Bands (0-4, 5-9,…, 60-64, 65+) and gender. Also provide the **average employer size** by Insurance Funding Type, Market Sector, Managed Care Type, and Product Type.

C. Please provide **member months** information for **small group**, **fully-insured accounts** broken down by Managed Care Type and Product Type, by size (**using size bands that correspond to the payer's rating bands** and excluding individual policies in the merged market from membership). For employer groups with multiple product or managed care types, the size band should be based on the total employer size, and not the size of the population enrolled in each type. For example, for an employer group of size 20 that has 5 employees enrolled in a PPO for the entire year and 15 enrolled in an HMO for the entire year: 60 member months (5*12) would be reported in the size band including size 20 under Managed Care Type "PPO", while 180 member months (15*12) would be reported in the size band including size 20 under "HMO."

PREMIUMS & CLAIMS

D. Please provide the following information for **fully- and self-insured accounts** by Market Sector, Managed Care Type, and Product Type:

- Earned Premiums [Fully-Insured Only]
  - Earned Premiums
  - Earned Premiums Net of MLR Rebates[1]
- Administrative Service Fees [Self-Insured Only]
- Percent of Benefits Not Carved Out
- Claims:
  - Allowed In-network
  - Allowed Out-of-network
  - Incurred In-network
  - Incurred Out-of-network
- *2014 Payer "3R" Totals[2] [Not Needed w/ May 6th Submission]*

[1] For the May submission, payers should reflect their best estimates of 2014 MLR rebates within the Mid-Size, Large, and Jumbo Market Sectors. CHIA will request 2014 MLR rebates for the Individual and Small Group Market Sectors at a later date.
[2] 3R totals - Risk Adjustment Transfer, Federal Transitional Reinsurance, and Risk Corridor amounts - are not expected to be submitted with this Request. See Definitions. CHIA will follow-up to collect this data after reconciliation in July.

RECONCILIATION

E. Please explain any known discrepancies between the data provided in (A), (B), and (D) with those provided in the following documents for 2012, 2013, and 2014 (where available by May 2015):

- Massachusetts Division of Insurance's "Annual Comprehensive Financial Statement"
- US Center for Consumer Information and Insurance Oversight's (CCIIO) "Medical Loss Ratio Reporting Form"
- National Association of Insurance Commissioners' (NAIC) "Supplemental Health Care Exhibit"

Certain Affordable Care Act provisions (such as Premium Stabilization programs) resulted in major changes to the merged market in 2014. These changes may make comparisons between May Premiums submissions and financial statements difficult for individual and small group sectors. CHIA will follow up with payers for final amounts in July.

Also, please explain any known discrepancies between the data provided in (A), (B), and (D) and previously submitted:

- CHIA Annual Premiums Data Requests

A detailed reconciliation is not required with previous Premiums submissions; rather, a listing of the major reasons for potential discrepancies should be provided.

For payer convenience, public payer data from 2012 and 2013 data, where available, have been included in the attached "Reconciliation Reference" workbook.

RATING FACTORS

F. Please provide rating factors for **fully-insured plans only** in effect for effective dates in December 2014 as follows: rating factors that are applied to base rates to develop premiums by market segment (when no employer-specific experience is available for Mid-Size and Large Groups), including but not limited to age/gender, area, group size, retention, and contract type. **Industry factors and benefit plan factors may be excluded**. Payers should define group size ranges as they would apply their rating factors.

CHIA will be hosting Technical Assistance Group (TAG) conference calls in March and April to answer technical questions. Questions may also be submitted at any time to Dianna Welch (information below) for quicker responses; answers may be reiterated on TAG calls and in updated FAQ documents.

The attached Data Template workbook should be used for data submission. **Separate workbooks should be submitted for each legal entity hosting business in Massachusetts within each payer or administrator, including entities that write only self-insured business**. Any elements not applicable to an entity's line of business should be noted; challenges should be discussed with Dianna Welch as soon as possible.

All quality-checked data submissions should be submitted to Dianna Welch by May 6, 2015 at 5pm. All submissions received after this date, as well as any incomplete data submitted, may be considered late.

Technical Questions:
Dianna Welch, FSA, MAAA
Oliver Wyman Actuarial Consulting, Inc.
dianna.welch@oliverwyman.com
(414) 277-4657

General Questions:
Kevin McAvey, Manager of Analytics
CHIA Health System Performance Analytic Team
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DEFINITIONS

"3 R" Amounts: *3R amounts - Risk Adjustment Transfer, Federal Transitional Reinsurance, and Risk Corridor amounts - are not expected to be submitted with this Request. CHIA will follow-up with payers to collect this data after the reconciliation process in July.*

- **Risk Adjustment Transfer Amount:** The amount that is received or owed as a result of the risk adjustment program that was put into place in Massachusetts' individual and small group markets effective in 2014. This amount is not due on the initial Request submission date.
- **Federal Transitional Reinsurance Amount:** The amount that is received as a result of the federal transitional reinsurance program that was put into place in the individual market effective 2014. This amount is not due on the initial Request submission date.
- **Risk Corridor Amount:** The amount that is received or owed as a result of the risk corridor program that was put into place in the individual and small group markets effective in 2014. This amount is not due on the initial Request submission date.

Administrative Service Fees: The fees earned by the payers/ASOs/TPAs for the full administration of a self-insured health plan, excluding any premiums collected for stop-loss coverage.

Average Employer Size: Equal to the number of covered employees divided by the number of employers. If multiple group IDs are maintained for a given employer, please use the number of employers in this calculation and not the number of group IDs. For a given employer, the number of covered employees should be the average for the calendar year.

If an employer has members in multiple Managed Care Type and/or Product Type categories, the average employer size would be calculated by taking the weighted average of the total group size where the weighting is done based on the number of employees in the given category. An example of how the calculation would be done if an employer has employees in multiple categories under Managed Care Type is shown below:

	Employees		
Employer Group	**HMO**	**PPO**	**Total**
A	200	50	**250**
B	0	300	**300**
C	75	200	**275**
D	150	0	**150**
Avg Employer Size	**219.1**	**286.4**	**243.8**

219.1 = (200*250 + 0*300 + 75*275 + 150*150)/(200 + 0 + 75 + 150)
286.4= (50*250 + 300*300 + 200*275 + 0*150)/(50 + 300 + 200 + 0)

Claims:

- **In-Network:** Allowed/incurred claims from providers with which the member's plan has or leverages a contractual agreement and negotiated rates.
- **Out-of-Network:** Allowed/incurred claims from providers with which the member's plan does not have or leverage a contractual agreement or negotiated rates.

The in- vs. out-of-network determination is made according to how benefits are administered to the member. If the reporting entity contracts with another entity to use the latter's network, and a member of the reporting entity receives services from a provider in that network that are covered at in-network benefit and cost sharing levels, the associated claim would be considered in-network.

- **Allowed Claims**: The total cost of claims after the provider or network discount, **if any**. Allowed Claims are equal to Incurred Claims plus member cost sharing; this should include medical claims, drug claims, capitation payments, and all other payments to providers, including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete. **For this Request, run-out beyond March 2015, as available, should be noted and estimated for outstanding claims incurred during calendar years 2012, 2013, and 2014.** This value should **not** include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.
- **Incurred Claims**: The total cost of claims, after the provider/network discount **(if any)** and after member cost sharing. This value should include medical claims, drug claims, and capitation payments, and all other payments to providers including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete. **For this Request, run-out beyond March 2015, as available, should be noted and estimated for outstanding claims incurred during calendar years 2012, 2013, and 2014.** This value should **not** include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.

Earned Premiums:

- **Earned Premiums:** Represents the total gross premiums earned prior to any Medical Loss Ratio (MLR) rebate payments, including any portion of the premium that is paid to a third party (e.g. Connector fees, reinsurance).
- **Earned Premiums Net of Rebates**: Represents the total gross premiums earned after removing Medical Loss Ratio (MLR) rebates and other "3R" amounts incurred during the year (though not necessarily paid during the year), including any portion of the premium that is paid to a third party (e.g. Connector fees, reinsurance). **For calendar year 2014, please include the best estimates for non-Merged Market MLR rebates; fully-insured Individual and Small Group market sector rebates may be left blank for May submission** as payers may not know their risk adjustment transfer amounts. CHIA will request this data at a later date.

Geographic Area: The 3-digit zip code of the member.

Insurance Funding Type:

- **Fully-Insured:** A plan where the employer contracts with an insurer to have that organization assume financial responsibility for employees' and their employees' dependents' medical claims and for all administrative costs.
- **Self-Insured:** A plan offered by employers who directly assume the major cost of health insurance for their employees' and their employees' dependents' medical claims. Employers that contract with insurance carriers or third party administrators for claims processing and other administrative services should be included under the Self-Insured Funding Type; these employers may or may not also purchase stop-loss coverage to protect against large claims.

Managed Care Type: A **mutually exclusive** breakdown of membership by Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and "Other". All plans should be included in one of these three categories, such that summing values across all Managed Care Types produces totals equal to those for a given Market Sector. **For plans that include multiple managed care types, the plan should be reported under the managed care type wherein most care is provided, where care is measured by Allowed Claims total dollar value**. For example, a Point of Service plan that uses a closed HMO network, but allows for indemnity coverage outside of the network, though provides roughly 95% of care (allowed claims total dollar value) through the HMO network, would be considered an HMO plan type. Please note that **Managed Care Type should be determined at the member level**, as based on the benefit plan selected by the member, and not the employer level. The allowed claims total dollar value of ALL members within a given benefit plan determine the managed care type of that plan.

- **HMO:** Plans that have a closed network of providers, outside of which coverage is not provided, except in emergencies. The plan may require members to coordinate care through a primary care physician, but may also provide open access to in-network providers.
- **PPO:** Plans that identify a network of "preferred providers", but that allow members to obtain coverage outside of the network, though typically at higher levels of cost-sharing. PPO plans generally do not require enrollees to select a primary care physician.
- **Other:** Plan types other than HMO and PPO, such as indemnity plans, which do not have networks of preferred providers.

The following example shows how multiple plans under one employer would be grouped into the different managed care type buckets. Please note that the "member months" field in the tables below includes both employees and dependents. Plans 1-3 are fairly straight-forward as there is only one managed care type for each of those plans, HMO, PPO, and Other respectively. Plan 4, however, a POS plan that combines HMO and Indemnity components, has multiple managed care types at the member level and, as a result, it would be grouped into the managed care type with the most allowed dollars, as shown in the "Plan 4 Detail" table. The Plan 4 Detail table contains the allowed claims experience for ALL members covered under that plan, such that all members in the plan are reported under the same managed care type even if a subset of the members experience an allowed claims percent that would result in a different managed care type if measured at the member level. In this example, plan 4 would be considered HMO, since the HMO managed care type had the most allowed dollars, and would be grouped under HMO for all reporting (membership, premium, claims, etc.).

For this one employer with four plans, the summation by managed care type is shown in the "Final Managed Care Type Information" table below.

EXAMPLE OF MULTIPLE PLANS FOR ONE EMPLOYER

Plan	Description	Member Months	Allowed Claims	Premium
1	HMO	180	$54,000	$67,500
2	PPO	120	$44,100	$42,000
3	Indemnity	96	$30,240	$43,200
4	POS	48	$14,000	$19,200

Plan 4 Detail

Plan Type	Allowed $	Allowed Pct
HMO	$9,000	64.3%
Indemnity	$5,000	35.7%

Since the majority of allowed claims for plan 4 fall under HMO, it is considered HMO for all reporting (membership, premium, claims, etc.)

Final Managed Care Type Information

Final Managed Care Type	Grouping	Members	Allowed Claims	Premium
HMO	Plans 1 & 4	228	$68,000	$86,700
PPO	Plan 2	120	$44,100	$42,000
Other	Plan 3	96	$30,240	$43,200

Throughout the definition of Managed Care Type, references to "plan" refer to a health benefit plan which is a unique set of network and cost sharing structure. For example, a payer's plans might include their "Broad Network Silver HMO $1,000" and "Broad Network Bronze PPO $5,000." The term "plan" is not intended to refer to an employer arrangement.

Market Sector: Average employer size segregated into the following categories: Individual products, **Small Group (1-50 eligible enrollees if fully-insured, 1-50 enrolled employees if self-insured)**, Mid-Size Group

(51-100 enrolled employees)[3], Large Group (101-499 enrolled employees), and Jumbo Group (500+ enrolled employees). In the **Small Group fully-insured market segment**, please include **only those small employers that meet the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04**.

Percent of Benefits Not Carved Out: The approximate percentage of a comprehensive package of benefits (similar to Essential Health Benefits) that the corresponding Allowed Claims cover. This value should be less than 100% when certain coverage, such as prescription drugs or behavioral health services, are carved out and not paid for by the plan. This value should be similar to the comparison of "Partial Claims" to "Full Claims" in the CHIA Total Medical Expense (TME) request.

The percent of benefits not carved out must be estimated when the reporting entity does not have access to the actual data for benefits that are carved out to another vendor. A simplified example is provided below.

- 1,000 members have comprehensive coverage provided by the reporting entity
- 500 members have only medical coverage provided by the reporting entity; pharmacy coverage is carved out to a pharmacy benefits manager
- Based on those members that have comprehensive coverage with the reporting entity, it is known that in 2014 80% of total allowed claims were for medical services and 20% of total allowed claims were for pharmacy services. These percentages should be calculated in aggregate across all market sectors, funding type, managed care types, and product types for a given calendar year. If the reporting entity lacks sufficient data for members with comprehensive coverage, it may combine its data with that of any affiliated entities.

The 2014 Percent of Benefits Not Carved Out for this segment is 93%. (1,000 * 100% + 500 * 80%) / (1,000 + 500) = 93%

Product Type: Groupings based upon whether plans are high-deductible health plans (HDHPs) and/or health plans that utilize tiered networks. These groupings are not mutually exclusive, nor will they include all plans. Please note that the **Product Type should be determined at the member level**, as based on the benefit plan selected by the member, and not the employer level.

- **HDHPs (as defined by individual deductible level only):** Plans with an individual deductible greater than or equal to the qualifying definition for a high deductible health plan, which is $1,200 for 2012 and $1,250 for 2013 and 2014 (for the most preferred network or tier, if applicable). The plan does not need to be a qualified high deductible health plan in order to be considered an HDHP for this purpose. Only a plan's individual deductible level must be satisfied to be included in this breakout for our purposes. For example, four members of a family plan would only be considered to be in an HDHP in 2014 for this data request's purpose if the individual deductible for that product is equal to or exceeds $1,250 in 2014; the deductible for the family plan itself is inconsequential.
- **Tiered Networks:** Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A Tiered Network is different than a plan only splitting benefits by in-network vs. out-of-network; a Tiered Network will have varying degrees of payments for in-network providers. For example, a tiered HMO plan may segment a payer's HMO network into two tiers, with a member paying a $500 inpatient copay per non-emergency admission at a Tier 1 hospital and a $1,000 inpatient copay per non-emergency admission at a Tier 2 hospital.

  A plan that has different cost sharing for different types of providers is not, by default, considered a

[3] Fully-insured employers that have fewer than 51 enrollees, but do not meet the definition of an "Eligible Small Business or Group", should be included in the Mid-Size Group

Tiered Network (i.e. a plan that has a different copay for primary care physicians than specialists would not be considered a tiered network on that criterion alone). However, if the plan has different cost sharing within a provider type depending upon the provider selected, then the plan would be considered a Tiered Network plan.

A plan need not have all provider types subject to tiering in order to be considered a Tiered Network plan for this purpose (i.e. a plan that tiers only hospitals is a Tiered Network, similarly, a plan that tiers only physicians is also here considered a Tiered Network).

Please see the FAQ (Managed Care Type and Product Type Clarification section) for further information on what types of plans should be considered Tiered Network.